HARDSHIP CONSIDERATIONS

Instructions

Please read all questions carefully. All "yes" answers must include a detailed explanation and appropriate documentation (attach additional pages as needed). Return the completed form to the Community Mental Health Center and/or Alcohol and Drug Provider or mail to the Division of Mental Health and/or Alcohol and Drug Abuse within 30 days of initial ineligibility determination. The Division of Mental Health or Alcohol and Drug Abuse will make a determination on eligibility within 30 days of receiving the competed form and necessary verifications.

Personal Information *(Please Print)* CID #: _____

Consumer Name: _____
(First) *(MI)* *(Last)*

Address: _____ Ph. #: _____
(Street) *(City)* *(State)* *(Zip)*

Parent/Guardian or Representative (if applicable):_____

Address (if different from above): _____

☐ **YES** ☐ **NO** Are you responsible for the care of extended family members or other household members? If yes, please list whose care you are responsible for and provide documentation of expenses.

_____

_____

☐ **YES** ☐ **NO** Do you have debt from prior chemical dependency treatments, illness, or other out of pocket medical expenses? For gambling services only, identify gambling losses/debt. If yes, please include bills or receipts of such debt and/or expenses.

_____

_____

_____

☐ **YES** ☐ **NO** Have you had any unforeseen/uncontrollable expenses (other than medical expenses)? If yes, please give a detailed description of the expenses and provide bills/receipts.

_____

_____

_____

☐ **YES** ☐ **NO** Are there two or more persons in your household who have disabilities or are chemically dependent? If yes, please list each individual who has a disability, or is chemically dependent, and what their specific disability is. Also provide documentation of expenses that result from such disabilities or expenses that result from chemical dependency related problems/treatment.

_____

_____

_____

☐ **YES** ☐ **NO** Do you or another household member have more than one disability? If yes, please list the individual and the specific disabilities. Also provide documentation of expenses that result from such disabilities.

_____

_____

_____

☐ **YES** ☐ **NO** Do you have extraordinary housing or costs of care (e.g., paying rent during hospitalization)? If yes, please describe and provide documentation.

_____

_____

☐ **YES** ☐ **NO** Do you have excessive transportation costs? If yes, please describe and provide documentation.

_____

_____

☐ **YES** ☐ **NO** Do you have other expenses/circumstances that would make paying for mental health or chemical dependency services an undue financial stress (e.g., expenses incurred while gambling)? If yes, please describe and provide documentation.

_____

_____

_____

☐ **YES** ☐ **NO** Are you a person 18 years of age or older with a mental health and/or chemical dependency living with a parent or sibling because no other satisfactory living arrangement is available? If so, enter parent or siblings income below so it may be deducted from the Means 101.

_____

_____

I hereby attest that this information is true and correct. I understand that any false statements that I make and any failure on my part to report change in circumstance which affect my eligibility could result in my being responsible for reimbursement of services provided and/or ineligibility for services.

_____

Signature (Consumer or Parent/Guardian) Date

Division of Mental Health or Division of Alcohol and Drug Abuse Hillsview Properties Plaza, East Highway 34 c/o 500 East Capitol Pierre, SD 57501 Mental Health Phone (605) 773-5991 or 1-800-265-9684 Alcohol and Drug Phone: (605) 773-3123	**Division of Mental Health/Division of Alcohol & Drug Abuse Use Only** ☐ Eligible ☐ Ineligible Date Reviewed: Signature of Reviewers: Signature of Assistant Director: